Form Instructions
"DETAILED EXPLANATION OF NON-COVERAGE"
CMS-10095-B

A Medicare+Choice (M+C) organization must provide a completed copy of this notice to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 422.626(e)(1), and must be provided no later than close of business of the day of the QIO's notification.

This is a standard notice. M+C organizations should not deviate from the content of the form except where indicated.

Heading

Insert logo here: **Not required**. M+C organizations may elect to place their logo in this space. The name and address of the M+C organization must be immediately under the logo, if not incorporated into the logo. If no logo is used, the name and address and telephone number of the M+C organization must appear above the title of the form.

Date: Fill in the date the notice is generated by the M+C organization.

Patient Name: Fill in the enrollee's full name.

Member ID number: Fill in the enrollee's Medical Record or ID number.

{Insert type} – Insert the kind of service being terminated, i.e., skilled nursing, home health, or comprehensive outpatient rehabilitation services.

Bullet # 1 Indicate whether the type of review involves medical necessity, coverage limitations, or both.

Bullet # 2 The facts used to make this decision: Fill in the patient-specific information that describes the current functioning and progress of the enrollee with respect to the services being provided. Use full sentences in plain English. Alternatively, if coverage is being terminated because of benefit exhaustion or non-Medicare covered services, describe how the enrollee's benefit does not cover the services.

Bullet # 3 The detailed explanation of why your services are no longer covered under your M+C plan: Fill in the detailed and specific reasons why services are either no longer reasonable or necessary for the enrollee or longer covered according to the Medicare coverage guidelines. Describe how the enrollee does not meet these guidelines.

Bullet # 4 The M+C plan policy, provision or rationale used in the decision: Fill in the reasons why services are either no longer reasonable or necessary for the enrollee or are no longer covered according to the M+C organization's policy guidelines. Describe how the enrollee does not meet these guidelines. If the M+C organization relied exclusively on the Medicare coverage guidelines, indicate here.

If you would like a copy of the policy: If the M+C organization has not provided the Medicare guidelines or policy used to decide the termination date, inform the enrollee of how and where to obtain the policy. The M+C organization should provide a telephone number for enrollees to get a copy of the relevant documents sent to the QIO. If a provider has been delegated to supply this information, the provider's contact number should be included.